FOR OHF USE

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0030015

Facility Name: WESTMONT CONVALESCENT CENTER

Address: 6501 SOUTH CASS AVENUE (Number) WESTMONT (City) 60559 (Zip Code)

County: DUPAGE

Telephone Number: (630) 960-2026 **Fax #** (630) 960-0480

IDPA ID Number: 36-3376606

Date of Initial License for Current Owners: 09/01/85

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust	X	Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2005 to 12/31/2005 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) FLORA WEISS
(Title) GENERAL PARTNER

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD, 3750 W DEVON, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	108	Skilled (SNF)	108	39,420	1
2		Skilled Pediatric (SNF/PED)			2
3	107	Intermediate (ICF)	107	39,055	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	215	TOTALS	215	78,475	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	10,482	5,154	8,973	24,609	8
9	SNF/PED					9
10	ICF	35,818	11,439		47,257	10
11	ICF/DD			23	23	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	46,300	16,593	8,996	71,889	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.61%

D. How many bed-hold days during this year were paid by the Department? _____ (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 09/01/85

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 09/01/85 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 43 and days of care provided 7,732

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2005 Fiscal Year: 12/31/2005

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	330,324	23,790	6,017	360,131		360,131		360,131			1
2	Food Purchase		270,722		270,722		270,722	(12,170)	258,552			2
3	Housekeeping	262,161	47,860		310,021		310,021		310,021			3
4	Laundry	163,799	23,752	3,141	190,692		190,692		190,692			4
5	Heat and Other Utilities			254,230	254,230		254,230		254,230			5
6	Maintenance	83,873	47,221	28,779	159,873		159,873	770	160,643			6
7	Other (specify):*	32,710		19,448	52,158		52,158		52,158			7
8	**TOTAL General Services**	872,867	413,345	311,615	1,597,827		1,597,827	(11,400)	1,586,427			8
	B. Health Care and Programs											
9	Medical Director			49,820	49,820		49,820		49,820			9
10	Nursing and Medical Records	2,819,228	160,690	33,292	3,013,210		3,013,210		3,013,210			10
10a	Therapy	166,246	2,430	1,431	170,107		170,107		170,107			10a
11	Activities	168,281	2,524	6,869	177,674		177,674		177,674			11
12	Social Services	98,903		1,210	100,113		100,113		100,113			12
13	CNA Training			2,051	2,051		2,051		2,051			13
14	Program Transportation			3,021	3,021		3,021		3,021			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,252,658	165,644	97,694	3,515,996		3,515,996		3,515,996			16
	C. General Administration											
17	Administrative	234,108		1,060,000	1,294,108		1,294,108		1,294,108			17
18	Directors Fees											18
19	Professional Services			49,515	49,515		49,515		49,515			19
20	Dues, Fees, Subscriptions & Promotions			34,757	34,757		34,757	(16,440)	18,317			20
21	Clerical & General Office Expenses	182,200	27,835	24,176	234,211		234,211		234,211			21
22	Employee Benefits & Payroll Taxes			832,848	832,848		832,848		832,848			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,000	3,000		3,000		3,000			24
25	Other Admin. Staff Transportation			1,594	1,594		1,594		1,594			25
26	Insurance-Prop.Liab.Malpractice			207,976	207,976		207,976		207,976			26
27	Other (specify):*			23,389	23,389		23,389	(23,389)				27
28	**TOTAL General Administration**	416,308	27,835	2,237,255	2,681,398		2,681,398	(39,829)	2,641,569			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,541,833	606,824	2,646,564	7,795,221		7,795,221	(51,229)	7,743,992			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: WESTMONT CONVALESCENT CENTER #0030015 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	4,800	
	REPAIRS & MAINTENANCE		1,217	
			0	6,017
3	**HOUSEKEEPING**			
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		3,141	
			0	3,141
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		84,262	
	ELECTRICITY		87,891	
	WATER		82,077	
	CABLE TV - LOBBY		0	
			0	254,230
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		6,289	
	PAINTING & DECORATING		1,544	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		893	
	ELEVATOR MAINTENANCE & REPAIR		6,565	
	OUTSIDE LABOR		5,250	
	EXTERMINATING SERVICE		4,575	
	FIRE SERVICE		3,663	
			0	
			0	
			0	28,779
7	**OTHER**			
	SCAVENGER		19,448	
	SECURITY SERVICE		0	19,448
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	49,820	49,820

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	17,206	
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES			
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	1,128	
	PHARMACY CONSULTANT	XVIII B 39-2	12,858	
	UTILIZATION REVIEW FEES	XVIII B __-2	2,100	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
			0	
			0	33,292
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES			
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	1,431	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	1,431
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		6,456	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	413	
			0	6,869
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	1,210	
			0	1,210
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	2,051	2,051

Facility Name & ID Number WESTMONT CONVALESCENT CENTER #0030015 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		3,021	3,021
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	1,060,000	1,060,000
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	20,979	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	28,536	
			0	49,515
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	12,292	
	EMPLOYEE WANT ADS	XIX F	9,691	
	CONTRIBUTIONS	VI 20 XIX F	1,648	
	DUES & SUBSCRIPTIONS	XIX F	7,606	
	LICENSES & PERMITS	XIX F	1,020	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	150	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	2,350	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	0	34,757
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		224	
	EQUIPMENT REPAIR & MAINTENANCE		2,243	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	0	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		21,709	
	MESSENGER SERVICE		0	
			0	24,176

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	337,797	
	UNEMPLOYMENT COMPENSATION	XIX D	69,521	
	WORKERS COMPENSATION INSURANCI	XIX D	145,422	
	HOSPITALIZATION INSURANCE	XIX D	150,385	
	EMPLOYEE BENEFITS - OTHER	XIX D	128,049	
	EMPLOYEE PHYSICAL EXAMS	XIX D	1,674	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	832,848
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS			0
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	3,000	
	TRAVEL	XIX G	0	
			0	
			0	3,000
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		1,594	1,594
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		207,976	207,976
27	**OTHER**			
	BAD DEBTS	VI 24	23,389	
				23,389

GRAND TOTAL COLUMN 3 OTHER 2,646,564

WESTMONT CONVALESCENT CENTER
EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
12/31/2005

TOTAL FOOD PURCHASE	270,722	PATIENT MEALS	215667
LESS SALES TAX	(1,100)	ADD EMPLOYEE MEALS	0
NET FOOD	269,622	TOTAL MEALS/YEAR	215667
TOTAL PATIENT CENSUS	71,889	NET FOOD	269622
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	215667
TOTAL PATIENT MEALS	215667	COST PER MEAL	1.25
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY	0		
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
TOTAL EMPLOYEE MEALS	0		

Facility Name & ID Number WESTMONT CONVALESCENT CENTER #0030015 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			289,748	289,748		289,748	62,197	351,945			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			631,995	631,995		631,995	(104,620)	527,375			32
33	Real Estate Taxes			96,624	96,624		96,624		96,624			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			75,292	75,292		75,292		75,292			35
36	Other (specify):* Amort Def Mortg			21,201	21,201		21,201		21,201			36
37	TOTAL Ownership			1,114,860	1,114,860		1,114,860	(42,423)	1,072,437			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		258,766	300,316	559,082		559,082		559,082			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			117,713	117,713		117,713		117,713			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		258,766	418,029	676,795		676,795		676,795			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,541,833	865,590	4,179,453	9,586,876		9,586,876	(93,652)	9,493,224			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	62,197	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(11,070)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,100)	2		13
14	Non-Care Related Interest	(104,620)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(150)	20		17
18	Fines and Penalties		21		18
19	Entertainment		20		19
20	Contributions	(3,998)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(23,389)	27		24
25	Fund Raising, Advertising and Promotional	(12,292)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule SEE PAGE 5A	770			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (93,652)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (93,652)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS
WESTMONT CONVALESCENT CENTER
ID# 0030015
Report Period Beginning: 01/01/2005
Ending: 12/31/2005

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 770	6	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	770		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(12,170)	0	0	0	0	0	0	0	0	0	0	(12,170)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	770	0	0	0	0	0	0	0	0	0	0	770	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(11,400)	0	0	0	0	0	0	0	0	0	0	(11,400)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(16,440)	0	0	0	0	0	0	0	0	0	0	(16,440)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(23,389)	0	0	0	0	0	0	0	0	0	0	(23,389)	27
28	**TOTAL General Administration**	(39,829)	0	0	0	0	0	0	0	0	0	0	(39,829)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(51,229)	0	0	0	0	0	0	0	0	0	0	(51,229)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	62,197	0	0	0	0	0	0	0	0	0	0	62,197	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(104,620)	0	0	0	0	0	0	0	0	0	0	(104,620)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(42,423)	0	0	0	0	0	0	0	0	0	0	(42,423)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(93,652)	0	0	0	0	0	0	0	0	0	0	(93,652)	45

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED SCHEDULE						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	FLORA WEISS	GEN. PARTNER	ADMINISTRAT.	0.22				MGMT. FEE	$ 530,000	17-3	1
2	DANIEL WEISS	ADMINISTRATOR	ADMINISTRAT.	0.00	SEE ATTACHED			SALARY	174,652	17-1	2
3	SHIRLEY HOLT	GEN. PARTNER	ADMINISTRAT.	0.16				MGMT. FEE	530,000	17-3	3
4	RICHARD HOLT	SECURITY	SECURITY	0.00				OUTS. LAB	4,800	6-3	4
5	CAROLYN HOLT	CLERK	CLERICAL	0.00				SALARY	9,600	21-1	5
6	SHARON HAUGH	BOOKKEEPER	CLERICAL	0.09				SALARY	47,504	21-1	6
7	JANE HOLT	MDS. COMP. INPUT	COMP. INPUT	0.00				SALARY	12,000	10-1	7
8	VASCO HOLD	CLERK	IN SERV TRAIN	0.00				SALARY	25,200	10-1	8
9	AVRUM WEINFELD	CONSULTANT	COMP. CONS.	0.00	SEE ATTACHED			SALARY	20,183	21-1	9
10											10
11											11
12											12
13								TOTAL	$ 1,353,939		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	KEY COMMERCIAL		X	MORTGAGE	$87,556.00	05/01/98	$ 10,000,000	$ 8,571,541	05/01/23	7.2800	$ 631,995	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$87,556.00		$ 10,000,000	$ 8,571,541			$ 631,995	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC											10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 10,000,000	$ 8,571,541			$ 631,995	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2004 report.	$ 85,483	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$ 89,708	2
3. Under or (over) accrual (line 2 minus line 1).	$ 4,225	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$ 92,399	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$ 96,624	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2000	75,156	8
2001	81,217	9
2002	82,311	10
2003	84,637	11
2004	89,708	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 103% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2004 TAX BILL.

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME WESTMONT CONVALESCENT CENTER COUNTY DUPAGE

FACILITY IDPH LICENSE NUMBER 0030015

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	09-22-101-001	NURSING HOME	$ 85,469.58	$ 85,469.58
2.	09-22-101-002	NURSING HOME	$ 4,238.52	$ 4,238.52
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 89,708.10	$ 89,708.10

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 55,928 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 2

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1			1995	$ 349,103	1
2					2
3	TOTALS			$ 349,103	3

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	215		1995		$ 4,982,301	$ 127,751	39	$ 127,751	$	$ 1,378,770	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	FLOORING			1986	41,641	1,958	19	2,165	207	40,943	9
10	ROOF & WATER LINE			1987	31,143	989	20	1,557	568	28,797	10
11	IMPROVEMENTS			1988	44,614	1,416	31.5	1,416		24,775	11
12	IMPROVEMENTS			1989	40,935	1,299	31.5	1,299		21,375	12
13	DRIVEWAY			1989	17,137	980	15	1,142	162	15,748	13
14	IMPROVEMENTS			1990	37,367	1,186	31.5	1,186		18,332	14
15	IMPROVEMENTS			1991	45,002	1,428	31.5	1,428		20,467	15
16	IMPROVEMENTS			1992	49,649	1,577	31.5	1,577		21,196	16
17	ROOF TOP A/C UNITS			1993	9,100	289	31.5	289		3,733	17
18	IMPROVEMENTS			1993	53,243	1,366	39	1,366		16,925	18
19	IMPROVEMENTS			1994	31,230	801	39	801		9,328	19
20	FLOOR COVERING			1995	795	20	15	53	33	583	20
21	HAND RAIL			1995	2,249	58	39	58		631	21
22	FLOOR TILES			1995	5,471	140	39	140		1,488	22
23	WINDOW A/C UNITS			1995	14,146	363	39	363		3,795	23
24	ARJO TUB & ATTACHED PLUMBING			1995	12,056	309	39	309		3,258	24
25	ALARM			1995	1,337	34	39	34		356	25
26	LAUNDRY BUILDING			1995	35,000	897	39	897		9,232	26
27	ROOF			1995	5,520	142	39	142		1,461	27
28	WINDOWS			1995	9,478	243	39	243		2,481	28
29	DOOR EDGE & DOOR FRAME			1996	2,099	54	39	54		538	29
30	LAUNDRY BUILDING			1996	175,187	4,491	39	4,491		42,862	30
31	AIR COOLERS			1996	6,642	171	39	171		1,622	31
32	RACING CAGE			1996	3,987	102	39	102		973	32
33	HAND RAIL			1996	1,156	30	39	30		281	33
34	WINDOWS			1996	11,496	295	39	295		2,766	34
35	TACK ROOM			1996	2,139	55	39	55		511	35
36	NEW CONFERENCE ROOM-TILE			1997	2,938	76	39	76		630	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	INSTALL DIETARY DOOR	1997	$ 1,478	$ 38	39	$ 38	$	$ 315	37
38	NURSING STATION - 2ND FLOOR	1997	5,397	138	39	138		1,122	38
39	WINDON-NURSING OFFICE	1997	1,382	35	39	35		284	39
40	REPLACEMENT A/C HEATING UNIT	1997	1,107	28	39	28		251	40
41	NURSING STATION - FLOOR TILES, HANDRAILS	1997	4,927	126	39	126		972	41
42	THE PARKING LOT	1998	42,711	2,990	15	2,990		20,738	42
43	KITCHEN BACK-REPLACE TILES, SIX ROOMS - INSTALL T	1998	6,223	160	39	160		1,263	43
44	INSTALL 6" SEWER, 10 EMERGENCY PULL CORD	1998	12,715	326	39	326		2,323	44
45	GENERATOR BACK-UP HOOK-UP TO ELEVATOR	1999	10,473	269	39	269		1,872	45
46	REPLACEMENT OF WATER HEATER - 1ST FLOOR	1999	3,452	89	39	89		597	46
47	ANSUL FIRE SUPPRESSI ON SYSTEM INSTALL	1999	1,495	38	39	38		255	47
48	SEALCOATING, REPAIRS & LINING	1999	2,877	74	39	74		490	48
49	REMODELING F WING SHOWER ROOM	1999	8,988	230	39	230		1,505	49
50	REPLACE DEFECTIVE SMOKE DETECTORS	1999	2,370	61	39	61		394	50
51	THE NEW PROXIMITY ELEVATOR DOOR EDGE	1999	2,760	71	39	71		441	51
52	WATER HEATER - DIETARY	1999	2,931	75	39	75		459	52
53	ROOF TOP - TWO EXHAUST FANS	1999	3,073	79	39	79		484	53
54	TILE - DINING ROOM	1999	1,212	31	39	31		190	54
55	ROOF - REPAIRS AND COATINGS	1999	7,200	185	39	185		1,133	55
56	REPLACE HEAT EXCHANGER IN YORK ROOF TOP UNIT	1999	2,738	70	39	70		423	56
57	WINDOW TREATMENT, DRAPERY	2000	3,265	286	20	163	(123)	978	57
58	WATER HEATER - DIETARY	2000	3,573	130	27.5	130		688	58
59	GENERAL CONSTRUCTION	2000	27,448	998	27.5	998		5,198	59
60	ROOF REPAIR	2000	4,200	153	27.5	153		797	60
61	REPLACE ELECTRICAL PANEL INTERIOR	2000	2,910	106	27.5	106		534	61
62	NEW A/C UNIT ROOF TOP	2000	4,694	171	27.5	171		862	62
63	WALLCOVERING, FLOORING, LIGHTING	2000	80,523	7,050	20	4,026	(3,024)	24,156	63
64	SHOWER ROOM RENOVATIONS	2001	30,586	1,112	27.5	1,112		5,329	64
65	DURO-LAST ROOFING SYSTEMS	2001	107,341	3,903	27.5	3,903		17,076	65
66	WATER HEATER - LAUNDRY	2001	9,108	331	27.5	331		1,338	66
67	ROOF TOP - HEATING & COOLING UNITS	2001	12,464	453	27.5	453		1,831	67
68	WALLCOVERING, FLOORING, LIGHTING	2001	270,861	28,054	20	13,543	(14,511)	67,715	68
69	WALLCOVERING, FLOORING, CARPETING	2002	29,114	2,979	20	1,456	(1,523)	5,824	69
70	TOTAL (lines 4 thru 69)		$ 6,386,654	$ 199,359		$ 181,148	$ (18,211)	$ 1,841,694	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 6,386,654	$ 199,359		$ 181,148	$ (18,211)	$ 1,841,694	1
2	FURNISH BRICK PIERS & SIGN, ASPHALT REPAIRS	2002	8,997	630	15	600	(30)	1,980	2
3	SHOWER ROOM	2002	30,924	1,125	27.5	1,125		3,609	3
4	INSTALLED TWO ROOF TOP UNITS, FIRE DAMPER	2002	9,010	328	27.5	328		998	4
5	NEW NURSES STATION WITH CORIAN TOP	2002	14,891	541	27.5	541		1,646	5
6	2ND FLOOR CORRIDOR-WALLCOVERING, LIGHT FIXTUR	2002	40,056	4,989	20	2,003	(2,986)	8,012	6
7	PRIVATE ROOM-FLOORING, WALLCOV., BATHROOM	2002	11,499	1,432	20	575	(857)	2,300	7
8	PRIVATE ROOM-FLOORING, WALLCOV., BATHROOM	2003	12,767	464	27.5	464		1,141	8
9	2ND FL NURSING STATION, CORRIDOR, RESIDENT ROOM	2003	31,152	1,133	27.5	1,133		2,785	9
10	THERAPY ROOM -FLOORING	2003	87,509	3,182	27.5	3,182		7,822	10
11	CONFERENCE ROOM-FLOORING	2003	2,073	76	27.5	76		187	11
12	LARGE DINING ROOM-BUILT IN TV CABINET	2004	7,421	270	27.5	270		394	12
13	TONE/VISUAL/VOICE NURSE CALL SYSTEM	2004	89,825	3,266	27.5	3,266		4,219	13
14	REMODEL OF RESIDENT ROOMS AND BATHROOMS	2004	50,925	1,852	27.5	1,852		2,238	14
15	RESIDENT ROOMS-FLOORING	2005	9,821	253	27.5	253		253	15
16	INSTALL CABLING SYSTEM	2005	46,771	1,063	27.5	1,063		1,063	16
17	INSTALL TWO AUTOMATIC SLIDING DOOR	2005	28,000	42	27.5	42		42	17
18	1ST FLOOR CORRIDORS-WALLCOVERING, SIGNAGE	2005	58,286	11,657	20	2,914	(8,743)	2,914	18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,926,581	$ 231,662		$ 200,835	$ (30,827)	$ 1,883,297	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 2,118,554	$ 40,592	$ 146,449	$ 105,857		$ 2,175,499	71
72	Current Year Purchases	87,468	17,494	4,661	(12,833)		4,661	72
73	Fully Depreciated Assets	246,728						73
74								74
75	TOTALS	$ 2,452,750	$ 58,086	$ 151,110	$ 93,024		$ 2,180,160	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 9,728,434	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 289,748	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 351,945	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 62,197	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,063,457	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 36,976 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	ADMINISTRATIVE	2001 BMW	$ #######	$ 12,780	17
18	ADMINISTRATIVE	2004 LEXUS	#######	9,300	18
19	ADMINISTRATIVE	2005 TOYOTA	775.00	12,588	19
20	HSKP, MAINT	2004 FORD PASS VAN	575.00	3,648	20
21	TOTAL		$ #######	$ 38,316	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [X]
- HOURS PER CNA 130

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$ 955	$	$ 955
2	Books and Supplies		1,096		1,096
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$ 2,051	$	$ 2,051
10	SUM OF line 9, col. 1 and 2 (e)	$ 2,051			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	8
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	8

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 135,178	$		$ 135,178	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			27,784			27,784	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			137,354			137,354	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				215,538		215,538	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	LAB,RADIOLOGY,TUBE FEEDING Other (specify): MEDICAL SUPPLIES	39-2 39-2					34,843 8,385		34,843 8,385	13
14	TOTAL			$		$ 300,316	$ 258,766		$ 559,082	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2005 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,270,898	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 30,000)	1,264,904		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	264,750		6
7	Other Prepaid Expenses	43,732		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Real Estate $ Ins Escrow	92,609		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,936,893	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	349,103		13
14	Buildings, at Historical Cost	4,982,301		14
15	Leasehold Improvements, at Historical Cost	1,944,280		15
16	Equipment, at Historical Cost	2,452,750		16
17	Accumulated Depreciation (book methods)	(4,508,913)		17
18	Deferred Charges	254,413		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): AMORT OF DEF MTG COST	(162,443)		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 5,311,491	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 8,248,384	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 185,012	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	149,323		30
31	Accrued Taxes Payable (excluding real estate taxes)	61,377		31
32	Accrued Real Estate Taxes(Sch.IX-B)	92,399		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 488,111	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	8,571,541		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 8,571,541	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 9,059,652	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (811,268)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 8,248,384	$	48

*(See instructions.)

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,018,726)	1
2	Restatements (describe):		2
3	ROUNDING	(2)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,018,728)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,303,960	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(1,096,500)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 207,460	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (811,268)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 10,506,141	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 10,506,141	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	236,075	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 236,075	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	104,620	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 104,620	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	DISCOUNTS	11,070	28
28a	COMPUTER INCOME	43,400	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 54,470	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,901,306	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,597,827	31
32	Health Care	3,515,996	32
33	General Administration	2,681,398	33
	B. Capital Expense		
34	Ownership	1,114,860	34
	C. Ancillary Expense		
35	Special Cost Centers	559,082	35
36	Provider Participation Fee	117,713	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,586,876	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,314,430	41
42	**Income Taxes**	(10,470)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,303,960	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** NO **If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,156	2,276	$ 83,283	$ 36.59	1
2	Assistant Director of Nursing	2,125	2,243	62,108	27.69	2
3	Registered Nurses	42,772	46,988	1,149,887	24.47	3
4	Licensed Practical Nurses	6,891	7,636	174,563	22.86	4
5	CNAs & Orderlies	109,218	112,061	1,093,177	9.76	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	9,586	11,106	166,246	14.97	8
9	Activity Director	4,168	4,646	68,267	14.69	9
10	Activity Assistants	11,355	11,851	100,014	8.44	10
11	Social Service Workers	6,109	6,648	98,903	14.88	11
12	Dietician					12
13	Food Service Supervisor	2,113	2,367	61,723	26.08	13
14	Head Cook					14
15	Cook Helpers/Assistants	27,416	29,284	268,601	9.17	15
16	Dishwashers					16
17	Maintenance Workers	6,069	6,398	83,873	13.11	17
18	Housekeepers	34,889	36,289	262,161	7.22	18
19	Laundry	21,957	22,757	163,799	7.20	19
20	Administrator	3,774	4,088	174,652	42.72	20
21	Assistant Administrator	1,604	1,680	59,456	35.39	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	17,300	18,794	182,200	9.69	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	3,846	4,070	50,065	12.30	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	13,576	15,434	206,145	13.36	31
32	Other Health Care(specify)					32
33	Other(specify) SECURITY	1,163	1,163	32,710	28.13	33
34	TOTAL (lines 1 - 33)	328,087	347,779	$ 4,541,833 *	$ 13.06	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	96	$ 4,800	1-3	35
36	Medical Director	Monthly Fee	49,820	9-3	36
37	Medical Records Consultant	21	1,128	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant	Monthly Fee	12,858	10-3	39
40	Physical Therapy Consultant	27	1,431	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	8	413	11-3	44
45	Social Service Consultant	22	1,210	12-3	45
46	Other(specify)				46
47	Utilization Review Fees	Monthly Fee	2,100	10a-3	47
48					48
49	TOTAL (lines 35 - 48)	174	$ 73,760		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	216	$ 9,504	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Certified Nurse Assistants/Aides	962	7,702	10-3	52
53	TOTAL (lines 50 - 52)	1,178	$ 17,206		53

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
DANIEL WEISS	ADMIN	0	$ 174,652
BARBARA WULF	ASST ADMIN	0	25,581
DAVID CHEPLOWITZ	ASST ADMIN	0	33,875
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 234,108

B. Administrative - Other

Description		Amount
WESTMONT G.P.	MANAGEMENT FEES	$ 1,060,000
TOTAL (agree to Schedule V, line 17, col. 3)		$ 1,060,000
(Attach a copy of any management service agreement)		

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		49,515
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 49,515

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 145,422
Unemployment Compensation Insurance	69,521
FICA Taxes	337,797
Employee Health Insurance	150,385
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	128,049
EMPLOYEE PHYSICAL EXAMS	1,674
PENSION/PROFIT SHARING PLANS	0
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 832,848

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	9,691
Health Care Worker Background Check	0
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	12,292
TRUST/FRANCHISE/CONTRIB/ETC	4,148
LICENSES & PERMITS	1,020
DUES & SUBSCRIPTIONS	7,606
MGMT CO ALLOCATION	
TRUST/FRANCHISE/CONTRIB/ETC	(4,148)
Less: Public Relations Expense	(0)
Non-allowable advertising	(12,292)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 18,317

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
Seminar Expense	
	3,000
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,000

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1			$		$	$	$	$	$	$	$	$	$
2	PAINTING/DECORATIN	7/02	2,297	3YR	383	766	766	382					
3	PAINTING/DECORATIN	7/03	2,188	3YR		365	729	729	365				
4	PAINTING/DECORATIN	7/04	2,834	3YR			472	945	945	472			
5	PAINTING/DECORATIN	7/05	1,544	3YR				258	514	514	258		
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 8,863		$ 383	$ 1,131	$ 1,967	$ 2,314	$ 1,824	$ 986	$ 258	$	$

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL LONG TERM CARE $7576**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **37,455** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES **X** NO If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
WESTMONT TERRACE NURSING CENTER, # 0025981 09/1/85

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **117,713**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees